STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100064	A. BUILDING: _____ B. WING _____	C 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN COUNTY MANOR I LLC	2820 RICHARD STREET HOPKINSVILLE, KY 42240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments A Complaint Survey investigating KY00048652, KY00048658, and KY00048316 was initiated on 06/25/2026 and concluded on 06/26/2026. There were no regulatory deficiencies cited related to KY00048316. Deficiencies were cited at P0045, P0090, and P0210 for KY00048652 and KY00048658. Survey Census: 43. Sample Size: 10.	P 000		
P 045	902 KAR 20:036 4(2)(a-b) Section 4. Administration and Operation Section 4. Administration and Operation. (2) Administrator. (a) The administrator shall: 1. Be responsible for the day-to-day operation of the PCH or SPCH; and 2. Designate one (1) or more staff to act on behalf of the administrator or to perform the administrator's responsibilities in the administrator's absence. (b) Each SPCH shall ensure that the administrator completes the mental illness or intellectual disability training workshop established by 921 KAR 2:015, Section 14, within six (6) months of hire and every two (2) years thereafter.	P 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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P 045	Continued From page 1	P 045		

This requirement is not met as evidenced by:
Based on interview, record review, document review, and review of the facility's policies, the facility failed to have an Administrator with minimum requirements to ensure adequate supervision of resident's with mental health diagnoses were met for 1 of 43 residents (Resident (R)1).

The findings include:

Review of the facility's policy titled, "Plan of Care", not dated, revealed changes in the resident's condition would be reported to the provider. Per the policy, the purpose was to ensure residents received care consistent with provider recommendations.

Review of the facility's policy titled, "Resident's Rights", not dated, revealed the facility will ensure residents are treated with respect, dignity, and consideration at all times.

Review of the "Resident Admission Agreement" signed by R1's guardian, dated February 4, 2025, revealed the Administrator authorized all admissions to this facility and shall transfer a resident when they require a higher level of care, when the resident is a danger to self or others or for nonpayment concerns.

Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 01/27/2025 with diagnoses of schizophrenia, sleep apnea, and cerebral palsy.

Review of R1's Care plan titled "Dx: Schizophrenia", dated January 27, 2025, revealed

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to be aware of resident's mood and tell the resident what you are needing to do and get permission.

Review of the facility incident report revealed R1 had a strong odor of alcohol on 06/17/2026 at 4:51 PM and withheld R1's Klonpin 0.5 mg due to drinking alcohol and also he was asleep outside under the facility carport and another resident assisted R1 to his room. It was further revealed several residents had been reported drunk including R1 and R1 was found with no pulse when staff was doing rounds on 06/18/2026 at 10:46 AM.

Review of R1's "Medication Administrative Record", dated 06/17/2026 at 7:00 PM revealed medications buspirone 10 mg, famotidine 20 mg, haloperidol 10 mg, lithium carbonate 450 mg extended release, methocarbam 750 mg, quetiapine 400 mg extended release, and quetiapine 300 mg extended release was administered.

Review of R1's medical record revealed there was no documentation of notifications made to the primary care or psychiatric provider that R1 had been consuming alcohol on a regular basis. It was further revealed the Eventus psychiatric provider was informed on 06/17/2026 R1 had a strong odor of alcohol.

Review of facesheets for multiple residents (R)s (R2, R3, R4, R5, R6, R7, R8, R9, and R10) revealed mental health diagnoses.

During an interview with multiple residents(R)s (R2, R3, R5, R7,and R9) on 06/25/2026, it was revealed R1 drank alcohol on a regular basis at the pavilion on the premises of the facility, and

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P 045	Continued From page 3	P 045		

could not walk independently back to his room and would require assistance.

During an interview with Head Aide on 06/25/2026 at 3:45 PM, she stated residents "party" by listening to loud music and drinking alcohol on the facility premises. She stated R1 was always part of the party and that she knew residents (R) (R5, R7, R8, R9, and R10) were drinking and / or doing drugs when residents were talking with a slur, dancing around when usual behaviors included being quiet and not talking at all. The Head Aide stated she did tell the med tech when residents were drinking and was unsure if a med tech informed the medical provider. She stated there was nothing staff could do and shrugged shoulders when asked if alcohol was allowed on premises.

During an interview with Head Dietary on 06/26/2026 at 8:30 AM, she stated she had witnessed residents under the influence of alcohol and drugs including R1and notified the med tech each time and unsure what med tech did. She stated she wanted to be sure med tech knew since residents took medications. Head Dietary stated she noticed several times R1 was acting differently and smelled like alcohol and did not know where he got the alcohol. She stated she notified a med tech each time.

During a telephone interview with Medication Technician (Med Tech) 1, on 06/26/2026 at 8:50 AM, he stated he had notified a provider numerous times for residents being under the influence of alcohol and / or illegal substances and then completed an incident report. Med Tech 1 stated he had witnessed R1 being under the influence of alcohol a lot and he would always ask R1 if he had been drinking and R1 would deny it

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P 045	Continued From page 4 and then be honest. During a telephone interview with Med Tech 2, on 06/26/2026 at 2:00 PM, she stated she had witnessed residents drinking including R1 and informed the Administrator up to twenty times in the last four to five months. Med Tech 2 stated she had taken empty bottles of beer and full cans of beer to the Administrator's office and the Administrator's response was "What do you want me to do"? She stated R1 was drunk and throwing up on three occasions in the past three months and she informed the Administrator each time. Med Tech 2 stated the Administrator stated each time that she could do nothing about it. Med Tech stated R1 was a good man, and the residents did not deserve the care they received. She further stated, "I feel defeated because of R1's death and the facility was aware of R1 drinking of alcohol multiple times" and repeatedly stated "this is so hard" as she cried. During a telephone interview with the Family Nurse Practitioner (FNP) on 06/25/2026 at 06/25/2026 at 3:11 PM, she stated she was not aware of R1 drinking alcohol until the facility notified the Eventus triage provider on 06/17/2026. The FNP stated R1 was on the medication Methocarbam and the risks of interaction with alcohol would include increased sedation. She further stated R1 had diagnoses of blood pressure, sleep apnea, no terminal diagnoses, and she collaborated with the psychiatric care provider. During an interview with Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 06/26/2026 at 10:35 AM, she stated she only had one visit with R1 and the Head Aide mentioned R1's alcohol use as the provider was leaving the	P 045		

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P 045	Continued From page 5 facility on 06/12/2026. The PMHNP reviewed R1's medications and stated the interaction between alcohol and Seroquel (quetiapine) could be fatal by increasing the likelihood of ventricular arrhythmia and the aspirin interaction with alcohol could cause a resident to stop breathing. The PMHNP stated she had concerns with drinking alcohol with any medications mainly for heart and / or mental health conditions. She further stated she did not think a one-time occurrence of consuming alcohol would be fatal. During a telephone interview with the Administrator on 06/26/2026 at 10:15 AM, when asked about the state required mental illness training for administrators, she stated all of her training was provided by her supervisor and that she did not complete training in mental illness / intellectual disability. The Administrator stated she did not approve alcohol and illegal substances on the premise and if she was aware, she would tell the resident that alcohol and illegal substances were not allowed, notify the guardian and would then notify the provider. The Administrator stated a transfer would be initiated if a resident was a risk to self or others and / or the resident asked to be moved to another facility, and if the resident was having behaviors such as outbursts, depression, and / or was unhappy with placement.	P 045		
P 090	902 KAR 20:036 4(8)(d) Section 4. Administration and Operation Section 4. Administration and Operation. (8) Transfer and discharge. (d) The administrator shall initiate a transfer through the resident's physician or appropriate agencies if the resident's condition is not within	P 090		

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P 090	Continued From page 6 the scope of services of the PCH or SPCH. This requirement is not met as evidenced by: Based on interview, record review, document review, and review of the facility's policies, the facility failed to ensure a transfer / discharge was initiated through the resident's physician, or appropriate agencies when the resident's condition was not within the scope of services of the facility for 1 of 43 residents (Resident (R)1). The findings include: Review of the facility's policy titled, "Plan of Care", not dated, revealed changes in the resident's condition would be reported to the provider. Per the policy, the purpose was to ensure residents received care consistent with provider recommendations. Review of the facility's policy titled, "Resident's Rights", not dated, revealed the facility would ensure residents are treated with respect, dignity, and consideration at all times. Review of the "Resident Admission Agreement" signed by R1's guardian, dated February 4, 2025, revealed the Administrator authorized all admissions to this facility and shall transfer a resident when they required a higher level of care, when the resident was a danger to self or others, or due to nonpayment.	P 090		

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P 090	Continued From page 7	P 090		

Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 01/27/2025 with diagnoses of schizophrenia, sleep apnea, and cerebral palsy.

Review of R1's Care plan titled "Dx: Schizophrenia", dated January 27, 2025, revealed to be aware of resident's mood and tell the resident what you are needing to do and get permission.

Review of the facility incident report revealed R1 had a strong odor of alcohol on 06/17/2026 at 4:51 PM and the staff withheld R1's Klonpin 0.5 mg due to drinking alcohol and also was asleep outside under the facility carport and that another resident assisted R1 to his room. It was further revealed several residents had been reported drunk including R1 and R1 was found with no pulse when staff was doing rounds on 06/18/2026 at 10:46 AM. During the initial recognition of the alcohol abuse on 06/17/2026 there was no evidence the facility took any efforts to transfer the resident to a higher level of care based on the suspicion of alcohol abuse mixed with psychiatric medications.

Review of R1's "Medication Administrative Record", dated 06/17/2026 at 7:00 PM revealed medications buspirone 10 mg, famotidine 20 mg, haloperidol 10 mg, lithium carbonate 450 mg extended release, methocarbam 750 mg, quetiapine 400 mg extended release, and quetiapine 300 mg extended release was administered.

Review of R1's medical record revealed there was no documentation of notification made to the primary care or psychiatric provider that R1 had been consuming alcohol on a regular basis. It

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P 090	Continued From page 8	P 090		

was further revealed the Eventus psychiatric provider was informed on 06/17/2026 R1 had a strong odor of alcohol.

During an interview with multiple residents (R)s (R2, R3, R5,R7,and R9) on 06/25/2026, revealed R1 drank alcohol on a regular basis at the pavilion on the premises of the facility, could not walk independently back to his room, and would require assistance.

During an interview with Head Aide on 06/25/2026 at 3:45 PM, she stated residents "party" by listening to loud music and drinking alcohol on the facility premises. She stated R1 was always part of the party and knew residents were drinking and / or doing drugs when residents were talking with a slur, dancing around when usual behaviors included being quiet and not talking at all. The Head Aide stated she did tell the med tech when residents were drinking and were unsure if the med tech informed the medical provider. She stated there was nothing staff could do and shrugged shoulders when asked if alcohol was allowed on the premises. The Head Aide stated on 06/18/2026 she did not think anything was wrong with R1 since he typically did not go to breakfast and breakfast was served around 8:00 AM. Later in the morning the Head Aide checked on R1 and discovered he had no pulse, she got help from other staff to put him on his back, she discovered his face was blue, then called EMS, police, and the Administrator.

During an interview with Head Dietary on 06/26/2026 at 8:30 AM, she stated she had witnessed residents under the influence of alcohol and drugs including R1 and notified the med tech each time and was unsure what the

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P 090	Continued From page 9	P 090		

med tech did. She stated she wanted to be sure the med tech knew since residents took medications. The Head Dietary stated she noticed several times R1 was acting differently and smelled like alcohol and did not know where he got the alcohol. She stated she notified a med tech each time. The Head Dietary stated residents being under the influence of alcohol or illegal substance was a concern and was unsure if there was a rule for the residents to have alcohol on the premises.

During a telephone interview with Medication Technician (Med Tech) 1, on 06/26/2026 at 8:50 AM, he stated he had notified a provider numerous times for residents being under the influence of alcohol and / or illegal substances and then completed an incident report. Med Tech 1 stated he had witnessed R1 being under the influence of alcohol a lot and he would always ask R1 if he had been drinking and R1 would deny it and then be honest. Med Tech 1 stated he filed an incident report, notified the provider, withheld medication, and informed the Administrator. He stated he last witnessed the resident under influence of alcohol six months ago or more and added he worked nights and residents were already in bed when I began my shift at times. Further review of R1s record had only the 06/17/2026 incident report and Administrator stated that all records had been provided on R1.

During a telephone interview with Med Tech 2, on 06/26/2026 at 2:00 PM, she stated she had witnessed residents drinking including R1 and informed the Administrator up to twenty times in the last four to five months. Med Tech 2 stated she had taken empty bottles of beer and full cans of beer to the Administrator's office and the Administrator's response was "What do you want

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P 090	Continued From page 10	P 090		

me to do"? She stated R1 was drunk and throwing up on three occasions in the past three months and she informed the Administrator each time. Med Tech 2 stated the Administrator stated each time that she could do nothing about it. The Med Tech stated R1 was a good man and the residents did not deserve the care they received. She further stated, "I feel defeated because of R1's death and the facility was aware of R1 drinking of alcohol multiple times" and repeatedly stated "this is so hard" as she cried.

During a telephone interview with the Family Nurse Practitioner (FNP) on 06/25/2026 at 3:11 PM, she stated she was not aware of R1 drinking alcohol until the facility notified the Eventus triage provider on 06/17/2026. The FNP stated R1 was on the medication Methocarbam and the risks of interaction with alcohol would include increased sedation. She further stated R1 had diagnoses of blood pressure, sleep apnea, no terminal diagnoses, and she collaborated with the psychiatric care provider.

During an interview with Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 06/26/2026 at 10:35 AM, she stated she only had one visit with R1 and the Head Aide mentioned R1's alcohol use as the provider was leaving the facility on 06/12/2026. The PMHNP reviewed R1's medications and stated the interaction between alcohol and Seroquel (quetiapine) could be fatal by increasing the likelihood of ventricular arrhythmia and the aspirin interaction with alcohol could cause him to stop breathing. The PMHNP stated she had concerns with drinking alcohol with any medications mainly for heart and / or mental health conditions. She further stated she did not think a one-time occurrence of consuming alcohol would be fatal.

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P 090	Continued From page 11 During a telephone interview with the facility Administrator on 06/26/2026 at 10:15 AM, she stated she did not approve alcohol and illegal substances on the facility premises and if she was aware, she would tell the resident that alcohol and illegal substances were not allowed, notify the guardian and the provider. The Administrator stated her expectation of staff was if alcohol was on the premises to take the alcohol away, complete an incident report, and then notify the guardian and the provider. She further stated she expected staff to discuss safety of all residents and the risks involved. The Administrator stated she was not aware of any alcohol being on the premises recently and last confiscated alcohol in September 2025. The Administrator stated she was not aware of R1 drinking alcohol before 06/17/2026. She further stated a transfer would be initiated if a resident is a risk to self or others, the resident asked to be moved to another facility, and if resident was having behaviors such as outbursts, depression, and / or was unhappy with placement.	P 090		
P 210	902 KAR 20:036 5(1)(a) Section 5. Provision of Services Section 5. Provision of Services. (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to ensure that the resident's health care needs are met; 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by	P 210		

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P 210	Continued From page 12 the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on interview, record review, document review, and review of the facility's policies, the facility failed to ensure appropriate supervision and monitoring of the resident to ensure that the resident's health care needs are met for 1 of 43 residents (Resident (R)1). The findings include: Review of R1's "Resident Identification Sheet" revealed the facility admitted R1 on 01/27/2025 with diagnoses of schizophrenia, sleep apnea, and cerebral palsy. Review of the facility's policy titled, "Plan of Care", not dated, revealed changes in the resident's condition will be reported to the provider. Per the policy, the purpose was to ensure residents received care consistent with provider recommendations. Review of the facility's policy titled, "Resident's Rights", not dated, revealed the facility will ensure residents are treated with respect, dignity, and consideration at all times.	P 210		

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P 210	Continued From page 13 Review of the facility incident report revealed R1 had a strong odor of alcohol on 06/17/2026 at 4:51 PM and the staff withheld R1's Klonpin 0.5 mg due to drinking alcohol as R1 was also asleep outside under the facility carport and another resident assisted R1 to his room. The report further revealed several residents had been reported drunk including R1 and R1 was found with no pulse when staff was doing rounds on 06/18/2026 at 10:46 AM. Review of R1's "Medication Administrative Record", dated 06/17/2026 at 7:00 PM revealed medications buspirone 10 mg, famotidine 20 mg, haloperidol 10 mg, lithium carbonate 450 mg extended release, methocarbam 750 mg, quetiapine 400 mg extended release, and quetiapine 300 mg extended release was administered. During an interview with multiple residents(R)s (R2, R3, R5, R7, and R9) on 06/25/2026, revealed R1 drank alcohol on a regular basis at the pavilion on the premises of the facility, could not walk independently back to his room, and would require assistance. During an interview with the Head Aide on 06/25/2026 at 3:45 PM, she stated residents "party" by listening to loud music and drinking alcohol on the facility premises unmonitored. She stated R1 was always part of the party and stated she knew residents were drinking and / or doing drugs when residents were talking with a slur, dancing around when usual behaviors included being quiet and not talking at all. The Head Aide stated she did tell the med tech when residents were drinking and was unsure if the med tech informed the medical provider. When asked	P 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100064	A. BUILDING: _____ B. WING _____	C 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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about proper supervison of the residents and the use of alcohol she stated there is nothing staff can do and shrugged shoulders.

During an interview with Head Dietary on 06/26/2026 at 8:30 AM, she stated she had witnessed residents under the influence of alcohol and drugs including R1and notified a med tech each time and was unsure what the med tech did. She stated she had noticed several times R1 was acting differently and smelled like alcohol and did not know where he got the alcohol. She stated she notified a med tech each time it happened.

During a telephone interview with Medication Technician (Med Tech) 1, on 06/26/2026 at 8:50 AM, he stated he had notified a provider numerous times for residents being under the influence of alcohol and / or illegal substances and then completed an incident report. Med Tech 1 stated he had witnessed R1 being under the influence of alcohol a lot and he would always ask R1 if he had been drinking and R1 would deny it and then be honest.

During a telephone interview with Med Tech 2, on 06/26/2026 at 2:00 PM, she stated she had witnessed residents drinking including R1 and informed the facility administrator up to twenty times in the last four to five months due to a lack of supervision and safety. Med Tech 2 stated she took empty bottles of beer and full cans of beer to the Administrator's office due to the lack of supervision and the Administrator's response was "What do you want me to do"? She stated R1 was drunk and throwing up on three occasions in the past three months and she informed the Administrator each time. Med Tech 2 stated the Administrator stated each time that she could do

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nothing about it. She further stated, "I feel defeated because of R1's death and the facility was aware of R1 drinking of alcohol multiple times" and repeatedly stated "this is so hard "as she cried.

During a telephone interview with the Family Nurse Practitioner (FNP) on 06/25/2026 at 3:11 PM, she stated she was not aware of R1 drinking alcohol until the facility notified the Eventus triage provider on 06/17/2026. FNP stated R1 was on the medication Methocarbam and the risks of interaction with alcohol would include increased sedation. She further stated R1 had diagnoses of blood pressure, sleep apnea, no terminal diagnoses, and she collaborated with the psychiatric care provider.

During an interview with the Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 06/26/2026 at 10:35 AM, she stated she only had one visit with R1, and the Head Aide mentioned R1's alcohol use as the provider was leaving the facility on 06/12/2026. The PMHNP reviewed R1's medications and stated the interaction between alcohol and Seroquel (quetiapine) can be fatal by increasing the likelihood of ventricular arrhythmia and the aspirin interaction with alcohol could stop him from breathing. She further stated she did not think a one-time occurrence of consuming alcohol would be fatal.

During a telephone interview with the facility Administrator on 06/26/2026 at 10:15 AM, she stated she did not approve alcohol and illegal substances on the facility premises and if she was aware, she would tell the residents that alcohol and illegal substances were not allowed, then notify the guardian and the provider. The Administrator stated her expectation of staff is if

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P 210	Continued From page 16 alcohol was on the premises to take the alcohol away, complete an incident report, and then notify the guardian and the provider. She further stated she expected staff to discuss the safety of all residents and the risks involved. The Administrator stated she was not aware of any alcohol being on the premises recently and last confiscated alcohol in September 2025. The Administrator stated she was not aware of R1 drinking alcohol before 06/17/2026. She further stated a transfer would be initiated if a resident was a risk to self or others and / or the resident asked to be moved to another facility, and if the resident was having behaviors such as outbursts, depression, and / or unhappy with placement.	P 210		